VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 6, 2019

Ms. Kassandra Losee, Manager
Sterling House At Rockingham
33 Atkinson Street
Bellows Falls, VT 05101-1502

Dear Ms. Losee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 3, 2019.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 01/16/2019
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0609	A. BUILDING: _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE AT ROCKINGHAM	33 ATKINSON STREET BELLOWS FALLS, VT 05101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey and an investigation of a self-report, was completed by the Division of Licensing and Protection from 1/2/19 -1/3/19. The following regulatory violations were identified:	R100		
R152 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (9) Review all therapeutic diets and food allergies with dietary staff as needed to assure nutritional standards are met and are consistent with physician orders; This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by the Registered Nurse (RN) Manager, the facility failed to ensure that the diet for 1 applicable resident on a puréed diet, ordered by the Speech/Language Pathologist PHD (SLP), was of a texture that would not place Resident #5 at risk for difficulty swallowing, and/or weight loss. The findings include the following: Per medical record review, progress notes dated 11/20/18 identify that MD suggests the resident have a modified barium swallow (test to identify swallowing problems). Referral was made, and the exam was scheduled for 12/19/18. Progress notes identify that the resident continued to have difficulty swallowing, was gagging with medication administration and did complain of throat pain. The exam was completed as ordered and determined that the resident has severe oral stage Dysphagia. (Dysphagia is defined as difficulty swallowing foods or liquids ranging from	R152	Please see attached.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Director 1/28/19

STATE FORM 6899 OLWH11 If continuation sheet 1 of 11

R152 - R266 POC's accepted 2/5/19 MBertrandRN/PMC

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R152	Continued From page 1 mild difficulty to complete and painful blockage.) The SLP recommended the following: Regular liquids and solids must be pudding consistency/pureed consistency solids. Other recommendations were related to the resident's dentures, safety and to monitor weight. Progress notes evidence in October 2018, the resident weighed 116 pounds, in November 108 pounds, in December 106 pounds and January 2019 100.4 pounds. The resident care plan identifies the SLP recommendation and weight monitoring. Per observation on 1/2/19 during the noon meal, the cook was observed pureeing spaghetti and meat balls with tomato sauce. The food was placed in a small food processor, processed and placed into a cup for easy handling. The puréed meal was not of smooth pudding consistency and small particles of meat and spaghetti were visible. This was brought to the attention of the Manager. Confirmation was made by the RN Manger that the purred food needed more liquid in processing to ensure the texture modification was as ordered.	R152		
R155 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced	R155		

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R155	Continued From page 2 by: Based on observations, record review and staff interview, the facility failed to follow physician orders for the administration of medication for 1 of 7 sampled residents, (Resident #6). The specific findings are as follows: Per record review, Resident #6 has a Physician's order dated for the month of January 2019, to administer Metamucil Sugar Free 1 tablespoonful dissolved in 8 ounces of water, at 8:00 AM, 2:00 PM, and 8:00 PM for constipation. The order suggests the resident drink the entire dose. Per observation at 8:15 AM on 1/3/19, the Medication Technician (Med. Tech.), prepared the daily medications for Resident #6, but omitted the scheduled Metamucil. Per review of the Medication Administration Record (MAR) for the month of January 2019, the Med. Tech. initialed the Metamucil as administered. Conformation was made by the Med. Tech. on 1/3/19 at 9:45 AM, that s/he had not administered the Metamucil and she had in fact initialed the MAR indicating the administration of the medication as ordered by the Physician.	R155		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the	R171		

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R171	Continued From page 3	R171		

medication regimen as ordered is appropriate and effective. At a minimum, this shall include:

(1) Documentation that medications were administered as ordered;
(2) All instances of refusal of medications, including the reason why and the actions taken by the home;
(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;
(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and
(5) For residents receiving psychoactive medications, a record of monitoring for side effects.
(6) All incidents of medication errors.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews, and record review, the facility failed to monitor for side effects for those residents receiving psychoactive medication, for 1 of 6 sampled residents (Resident #3). The specific findings include the following:

Per record review on 1/2/19 at approximately 2 PM, Resident #3 was admitted on 7/2/2018 with Physician's orders for the following psychoactive medications; Olanzapine (for Schizophrenia), Clonazapam (for anxiety), and Clomipramine (for depression). There is no evidence in the resident's medical record of any monitoring for side effects of the listed medications, since admission.

Confirmation was made by the Registered Nurse Manager/Director on 1/2/19 at approximately 2:45

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R171	Continued From page 4 PM that there was no evidence that monitoring for side effects from the use of psychoactive medications has been done.	R171		
R179 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on employee record review and confirmed by the Registered Nurse (RN) interview, the	R179		

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R179	Continued From page 5	R179		

facility failed to ensure that 4 of 5 direct care employees completed the required minimum 12 hours of annual training. The specific findings include the following:

In the presence of the RN Manager, who confirmed on 1/3/19 at 9:30 AM, the following information evidences that the employee did not meet the required annual training:

Employee #1 was hired on 6/2015 and has a total of 10.5 hours of training for the 2018 calendar year. The employee has not completed the mandatory programs in Emergency Response, Abuse/Neglect and Respectful Communication;

Employee #2 was hired on 10/2017 and has a total of 8.5 hours of training for the 2018 calendar year. The employee has not completed the mandatory programs in Emergency Response, Abuse/Neglect and Respectful Communication;

Employee #4 was hired on 12/2017 and has a total of 8.5 hours of training for the 2018 calendar year. The employee has not completed the mandatory programs in Fire Safety, Emergency Response, Abuse/Neglect and Respectful Communication;

Employee #5 was hired on 10/2017 and has a total of 11 hours of training for the 2018 calendar year. The employee has not completed the mandatory programs in Emergency Response, Abuse/Neglect and Respectful Communication.

R249 SS=F — VII. NUTRITION AND FOOD SERVICES — R249

7.2 Food Safety and Sanitation

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R249	Continued From page 6	R249		

7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices.

This REQUIREMENT is not met as evidenced by.
Based on observation and confirmed by the staff interview, the facility failed to ensure that food is stored utilizing safe handling practices. Observations included buttering bread with no hand/head protection, outdated cold cuts, peppers found with liquid slim in the storage bag and serving 1 of 17 residents (Resident #4), a second helping in a contaminated dish. The detailed findings are as follows:

During the kitchen tour on 1/2/19 at approximately 11:12 AM in the presence of the Manager and during the observation of the noon meal service the following practices were identified:

-Per observation at approximately 12:30 PM on 1/2/19, Resident #4 requested a second serving. The care provider returned to the main kitchen with the dirty/contaminated plate, placed meat balls in the resident's dish, using the large spoon sitting in the sauce with the meatballs, and then returned the spoon to the pan storing the sauce and meat balls. S/He then delivered the second helping to Resident #4;
-The facility cook on 1/2/19 was observed buttering bread with his/her bare hands for the resident's noon meal. The cook placed bread slices on the resident's plate and then proceeded serving food to the remaining residents;
-The refrigerator in the main kitchen was found with partially used yellow and orange peppers with a slimy white liquid, in a plastic bag dated

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R249	Continued From page 7 12/5/18: -A deli bag of smoked Virginia Ham partially used with a sell by date on 11/26/18; -A plastic storage bag with slices of what appeared to be pepperoni, with no date as to when it was placed in use or identification of what was contained in the bag; The cook and the manager both confirm on 1/2/19 at 11:50 AM that food is to be dated when put in use and is to be discarded after three (3) days. The Manager confirmed on 1/2/19 at the time of the tour and again on 1/3/19 at 8:30 AM that the above conditions were identified.	R249		
R251 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to store dry products to protect against dust, insects and all sources of contamination. The findings include the following: During the kitchen tour on 1/2/19 at approximately 11:12 AM in the presence of the Manager the following practices were identified: -a plastic multi gallon container storing sugar was	R251		

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R251	Continued From page 8 found with a cup used for scooping, stored in the container resting on the product; -a 40-ounce canister of hot cocoa mix, partially used, was found with the serving scoop stored in the canister resting on the product; -a 36-ounce canister of thicket opened on 12/24/18, partially used with the serving scoop stored in the canister resting on the product; -a 1-pound box of baking soda partially used with no date as to when it was put in use nor was the box sealed; -a 32-ounce bag of powdered sugar, partially used found unsealed; -an 8-ounce bag of ground pecans, partially used found unsealed; -a bag of donuts, with one donut remaining, was in the cabinet above the sink, open/unsealed and not dated. Confirmation was made by the manager, on 1/2/19 at approximately 11:35 AM that the above was identified concerns need to be corrected.	R251		
R253 SS=C	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by the facility Manager, the facility failed to ensure that the hood located above the main cook stove in the main kitchen is kept clean. The specific findings include the following:	R253		

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R253	Continued From page 9	R253		
	Per review of the main kitchen, in the presence of the Registered Nurse Manager on 1/2/19 at approximately 11:12 AM, confirmation was made the hood above the main cook stove was cleaned by contractors on 6/2018. Facility staff clean the inside of the hood, to include the slats, monthly. However, currently the slats have visual dust and grime accumulated, that could easily become dislodged and fall into the food being cooked on the stove top.			
R256 SS=F	IX. PHYSICAL PLANT	R256		
	9.1 Environment			
	9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.			
	This REQUIREMENT is not met as evidenced by: Based observation and confirmed by the Manager, the facility failed to ensure that the home was maintained in a safe, sanitary and comfortable interior evidenced by resident rooms, shared bathrooms and common areas in need of repairs. The specific findings include the following:			
	Per initial facility tour in the presence of the Director of Nurses (DNS) on 1/2/19 and confirmed by the Registered Nurse (RN) Manager on 1/3/18 at 8:35 AM, the following conditions were identified to be in need of repair:			
	1st Floor:			

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R266	Continued From page 10 -Room #5 has multiple areas of peeling paint on the walls in the resident's bed room; -Room #3 was found to have a hole, approximately 1 inch in diameter, behind the bedroom door. The sheet rock is sloughing off; -The dining room was found to have chipped paint along the wall opposite the windows and a cracked wall against the door; 2nd Floor: -Room #11 has no cover on the bathroom ceiling light fixture; -Room #14 bathroom which is shared by three (3) residents, has a broken switch plate, that is cracked and missing a portion of the left lower corner. The walls and ceiling of the bathroom also evidence peeling paint.	R266		

Sterling House At Rockingham, LLC
Residential Care
33 Atkinson Street
Bellows Falls, Vermont 05101
802-463-0137

Ms. Suzanne Leavitt
Div Licensing and Protection
Ladd Hall
Waterbury, VT

January 21, 2019

Plan of Correction for survey conducted January 3, 2019.

Resident Care and Home Services

R 152

1. Education provided to all staff on pureed diets, including a test needing to be completed by 1/25/2019. Resident #5's Speech Pathology report reposted for staff to read, and sign off they understand Resident #5 therapeutic diet. Must be read by 1/25/2019.
2. Nurse Managers will monitor meals given to Resident #5, and or any other therapeutic diets. Kitchen staff will need to demonstrate correct therapeutic diets once before able to provide meals for Residents.
3. Nursing Staff and or Kitchen manager will monitor therapeutic meals, along with random spot checks at meal times.
4. Paper test will be completed by 1/25/2019 and meal prep demonstrations will need to be completed by 2/1/2019.

R 155

1.Employee #5 was reoriented to medication passing expectations, policy and procedures and documentation. This RN held a staff meeting on 1/14/2019 where preliminary findings of survey were discussed. This RN will summarize and post Plan of Correction after submitted and accepted. Every employee will sign off after reading and retaining information.
2. Medication passers do get evaluated yearly but this RN will pay larger attention to detail during yearly evaluation to monitor documentation closer.

3. The nurses will perform random audits of medication passers and will make a spreadsheet to ensure every medication passer is meeting the expectations. Immediate action will take place if needing correction. May implement PRN meetings for medication passers, but will continue with PRN memos.
4. Every medication passer will be randomly monitored pulling, passing and documenting medications by 2/15/2019. Immediate action will take place if needing correction.

R 171

1. Immediate review of medication policy and correction of medication policy for residents on antipsychotics. Immediately reviewed all charts with residents who take antipsychotics. AIMS done for resident #3.
2. Nurses have a nurse calendar where Nurses write all residents appointments on. AIMS for said residents added to Nurse calendar. Nurses have monthly "to do" sheet. AIMS testing added for said residents.
3. Every nurse looks at calendar daily, and caregivers write daily appointments on whiteboard, where it gets checked off daily.
4. All charts will be audited along with an updated policy by 2/1/2019.

R 179

1. 2019 education plan outlined containing the seven requirements 1. Residents rights. 2. Fires safety and emergency evacuation. 3. Resident emergency response procedures. 4. Policy and procedures on mandatory reports of abuse, neglect and exploitation.5. Respectful interaction with residents. 6. Infection control measures. 7. General supervision and care of residents. Every staff members education will be reviewed, and will be given any education including the test they have missed by 3/1/2019.
2. Moving forward Nurses will meet every December to form a new Education Plan for the following year (making sure to include the seven requirements.) When a new employee is hired, will provide testing that they have missed for the calendar year. Looking into new and different ways to preform education.
3. Appointed nurses to help oversee all education. The nurses have formulated a binder with all testing material and has signature sheet for employees with clear deadlines on when test need to be completed. Nurses will monitor that employees are performing education. All staff will have two weeks to complete testing. If not completed by the end of two weeks, when employee comes to receive paycheck this RN will give written or verbal test.

4. Review of every caregivers education will be performed by the nurses. Missing test will be required to be completed by 3/1/2019. Moving forward will have a calendar year to have all requirements met. Nurses will meet every December to form a new Education Plan for the following year. When a new employee is hired, will provide testing that they have missed for the calendar year. All requirements will be met by 12/31 every year.

Nutrition and Food Services

R 249

1.This RN has appointed a kitchen Manager. This RN and Kitchen Manager have signed up to take the "Safe Serve" Course (March 2019) to ensure Sterling House is up to date on on safety and sanitary kitchen issues. This kitchen manager also is working on a spreadsheet to perform random audits of kitchen and staff. Will preform kitchen education and start a binder for kitchen communication.

2. This RN held a staff meeting on 1/14/2019 where preliminary findings of survey were discussed. This RN will summarize and post Plan Of Correction after submitted and accepted. Every employee will sign off after reading and retaining information. Kitchen Manager will hold kitchen staff meetings PRN for kitchen issues and findings.

3. Random audits of food/handling/serving and storage will be performed by nurses and kitchen manager. Gloves and proper food labels have been purchased immediately for kitchen use. Will label when food is bought/frozen/thawed.

4. Immediate actions were taken into place. Everything out dates, contaminated was thrown out and repurchased. Gloves we bought for the kitchen and required with food handling. Labels were purchased and placed on all new groceries. Staff educated about "second servings."

R251

1.This RN has appointed a kitchen Manager. This RN and Kitchen Manager have signed up to take the "Safe Serve" Course (March 2019) to ensure Sterling House is up to date on safety and sanitary kitchen issues. This kitchen manager also is working on a spreadsheet to perform random audits of kitchen including proper storage of food, to ensure food is labeled, sealed and not contaminated with scoops or spoons. Will preform kitchen education and start a binder for kitchen communication.

2. This RN held a staff meeting on 1/14/2019 where preliminary findings of survey were discussed. This RN will summarize and post Plan Of Correction after submitted and accepted. Every employee will sign off after reading and retaining information. Kitchen Manager will hold kitchen staff meetings PRN for kitchen issues and findings.

3. Random audits of food/handling/serving and storage will be performed by nurses and kitchen manager. Gloves and proper food labels have been purchased immediately for kitchen use. Will label when food is bought/frozen/thawed.

4. Immediate actions were taken into place. Everything out dates, contaminated was thrown out and repurchased. Gloves we bought for the kitchen and required with food handling. Labels were purchased and placed on all new groceries. Extra storage containers and bags purchased for safe sealing.

R253

1. Immediate action was taken to clean the stove hood. This was done by January 3, 2019.
2. Kitchen manager has updated kitchen cleaning spreadsheet to check on slates and hood weekly with mandatory cleaning slates every 2 weeks since 1 month appears to be too long.
3. Kitchen manager is monitoring this by random audits and spreadsheets.
4. The hood was cleaned that evening. Manager has been checking weekly on kitchen cleanliness. Spreadsheet will be fully updates by Feb 1, 2019.

Physical Plant

R 266

1. This RN has written up all request and given list to Maintenance person. Will start by finding the right time to fix said rooms according to Resident's schedule. (Example Resident 2 goes out most Thursdays with family.)
2. Have increased staff communication regarding environment. List started in Med room of potential problem areas, or current problem areas for Sterling House. Staff are aware to immediately inform this RN of unsatisfactory findings. Will have Maintenance person scheduled to be at Sterling House for a minimum of 2 hours a week and per diem; instead of just per diem. This will help ensure the maintenance of the house will be maintained. Will increase the hours if needed.
3. Maintenance person will be expected to routinely audit rooms including windows, ceilings, walls, carpet, molding and bathrooms if applicable. All rooms shall be audited once a month minimal. Findings will be reported to this RN.

4. It is hard to know how long the physical plant updates will take due to where the issues are (dining room, living room) where there usually are residents. If we wait until the nicer weather residents sit out on the porch, or we can go out for a meal while repairs are being made. Ideally things will get done as soon as possible, but will absolutely be corrected by June 1, 2019. Things like Room 14 switch plate has been replaced, and room 11 light fixture has been purchased.

Please feel free to contact me with any questions or concerns.

Sincerely,

Kassandra Losee, RN, Director